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ABSTRACT

One out of every seven people has some form of mental or emotional illness ranging from mild to severe. Fewer than one-third of those needing professional care treatment for their mental and emotional problems are receiving it. Some of the symptoms of psychosis are that the person lives in an imaginary world, hears voices, believes everyone is out to get him and has little control over what he does during his illness. Some neurosis can be so debilitating as to prevent a person's carrying on with his everyday activities. Some factors to consider in the lives of the mentally ill are long sieges of trouble or sickness, neglect or rejection in childhood, or constant criticism. Understanding that the troubled person's behavior may be more painful to him than to anyone else is the first step. "Do's" and "don't's" for working with mentally ill persons serve as a guide. Learning to observe if minor problems upset them, if they have trouble getting along with others, or if they are unable to stop thinking about their anxieties are key points to watch. An extensive literature review in the area of student education is included. (Author/BMW)

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Good Mental Health and Student
Mental Health Services in Higher Education

by

Boris Blai, Jr.

1979

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Good Mental Health and Student
Mental Health Services in Higher Education

Overview

How great is the need for mental health services? In the United States alone one in every seven people (about 32,000,000 in our entire population) have some form of mental or emotional illness. The severity of the condition ranges from mild to severe, and all of these individuals would benefit from professional help. Today, about twenty-one million families have someone in their household affected by mental illness. This is more than one in each four families.

Among children, mental illness is also reported in about the same proportion as adults; 3% have severe emotional problems and 8% have less severe difficulties, although the latter group members are still not able to function normally.

To-day, one person in every 35 (about 7 million) is receiving professional care treatment for mental and emotional problems. This is estimated to be less than one third of those needing such help. The overall cost to the nation for mental health services is very large. In 1974 it was estimated to be \$37 billion. This sum includes the cost of direct services paid by individuals, as well as by government and private industry carriers, research and manpower programs, and vocational rehabilitation services.

Of the total loss, approximately \$19 billion is in productive capacity; i.e. how much one is capable of producing. This would include potential earnings of non-working mentally ill, absenteeism, unemployment, and loss in purchasing power. This 'accounting' does not include intangible costs such as the personal misery to individuals suffering mental/emotional illnesses, and their friends and families. It also does not include the costs of accidents and crimes associated with mental illness.

Those who become better acquainted with the facts about mental and emotional illness are better able to deal with the problems involved. Perhaps the most important fact to remember about mental illness is that it is an illness; with proper care and treatment people can get better and lead normal lives. Asking

a mentally ill person to "snap out of it" is as unhelpful as expecting someone with a broken leg to forget about it !

Facts About Mental/Emotional Disorders

What are these mental and emotional illnesses that directly affect the lives of so many people? The following terms describe several different disorders of the mind that affect the way persons think, feel, and behave. Seldom do such illnesses appear suddenly. Usually there are early signs which qualified professionals can identify long before a breakdown occurs.

The term for the type of mental illness which is usually severe is psychosis. It is often characterized by the following symptoms:

- The person lives in an imaginary world, usually recognizing something of what goes on.
- The individual may 'hear' voices; think his food is poisoned; believe everyone is out to "get him"; may be either very depressed or very excited; may feel something terrible is about to happen to him, or that he has committed a terrible crime for which he is being punished; may imagine he has magical powers or that he is a famous person.
- The person suffering from a psychosis has little control over what he does during the time of his illness.
- Psychotic individuals are not insensitive, as is commonly believed. Many suffer intensely, and most respond gratefully to kindness and attention.
- Among those who are seriously mentally ill, only a few persons become over-active or violent; most are quiet, unexcited people.
- "Organic psychoses" are those stemming from physical causes. These can be nervous system injury, such as brain damage, the effects of poisonous chemicals, severe alcoholism and advanced infection. Others may result from bodily changes; e.g. those brought about by senility and hardening of the arteries.
- "Functional psychoses" are those for which there are no known physical causes. Examples are paranoid and affective psychosis. The most common of all is

schizophrenia, which is also one of the most baffling.

— Recently there has been a marked increase in the number of psychotic people returning to normal functioning. In this regard, almost anyone who suffers from a psychosis benefits from treatment - the earlier the treatment, the better the chance of recovery. Improvement of care in mental hospitals; new, modern treatment services; e.g. mental health services in general hospitals, community health centers (mental), and special treatment centers for mentally ill children; and the use of therapeutic drugs effectively used to control many symptoms of severe mental illnesses, have all contributed to this improvement.

The term for the type of mental illness which can cause a person severe distress and impair efficiency is neurosis (psychoneurosis). It can be as debilitating as psychoses although frequently the symptoms are not as severe. Some of its characteristics include:

— A neurosis may be so serious as to prevent a person from carrying on with his job, his schooling, or in his family, and may require treatment in a hospital. Or - another neurosis may be moderate, permitting a person to keep his daily routine but requiring some kind of therapy - not necessarily in a hospital.

— Neurotic symptoms may include one or more or a combination of the following: feeling unloved, inferior and inadequate - often without reason; excessive shyness; a constant sense of guilt, dread and fear; chronic tardiness and nervous tension, sleeplessness or the constant fear of physical illness to the point of imagining that one has "all the symptoms", certain pronounced phobias such as fear of high or closed-in places. We all have some of these feelings some of the time, but the neurotic person has them to a greater degree most of the time.

— Neuroses may also reveal themselves in physical symptoms. Many disorders - stomach ulcers, diabetes, arthritis and high blood pressure - can be emotional in origin. An everyday example of the effect emotions can have on the body is the so-called "nervous headache".

Racism and Mental Problems

"A major element in the prevention of mental illness and the promotion of mental health is the identification of factors contributing to mental illness.

"In the forward of the bibliography on Racism published by the National Institute of Mental Health in 1972, Dr. Bertram S. Brown, Director of the Institute, stated, 'Racism in this country is a product of more than three hundred years of systematic subordination of Indians and blacks by the white majority, and the later subordination of still other groups. It pervasively influences every single institution in our society.'....

"With reference to services for children, a conclusion of the Committee on Children of Minority Groups ... states that ('in terms of mental health, racism is a more pervasive and far more serious threat than childhood schizophrenia, mental retardation, psychoneurosis or any other mental derangement. Its destructive effects severely cripple the growth and development of millions of our citizens, both young and old alike. Yearly, it directly and indirectly causes more fatalities, disabilities and economic loss than any other single factor.' (1)

"Realizing that racism is indeed a large factor in the mental health of this country, it is the position of the Mental Health Association that:

(A) Racism in its various aspects and ramifications is a direct, causative precipitant of mental illness.

(B) The Association will take positive steps to end racism within the Mental Health Association.

(C) The Mental Health Association will urge its Divisions and Chapters as well as associated associations to eliminate racism in this country.

(D) The Mental Health Association will take positive steps to eliminate racism in this country." (2)

Dealing With Mental Problems

Like physical upsets, emotional upsets are very common. Both are signs that the system is reacting to some temporary stress or irritation which disturbs its routine functioning. Simple, minor emotional disturbances are a part of everyday

(1) "Position Statement on Racism As A Contributing Factor Toward Mental Illness" Mental Health Association, 1977, p.1.

(2) *ibid.* p2.

life; everyone is subject to them. For example, it is quite ordinary to fly into a rage over some petty annoyance; or to get terribly worried about some insignificant trifle; or to get "down in the dumps" for no apparent reason. Ordinarily such reactions come, last awhile, and then disappear.

However, there are some disturbances which don't go away "just like that". They linger on for hours, days, or even weeks. They become quite deep and intense, and affect the individual's overall behavior, feelings, and thoughts.

When a condition reaches this stage, it is no longer simply an upset or disturbance, but an actual mental or emotional illness. One is then dealing with a disturbed personality - the troubled people experiencing mental or emotional problems.

As an illness, such mental or emotional problems should be regarded with the same attitude with which physical illness is regarded. We now know that such mental or emotional illnesses have: (1) definite causes; (2) upset the system and make it behave abnormally; (3) require care and treatment and that when these are made available, improvement or outright recovery may be expected. These individuals who suffer from emotional or mental illnesses are of concern to the community at large because what they do and say generally affects everyone else who works or studies or lives with them. But they are also of concern as sick human beings; as people in need of understanding.

Today, mental health professionals agree that understanding can keep minor upsets from becoming worse, and that it can also help mentally sick people to recover. Such understanding can take two forms - the first is sympathetic understanding which is the kind commonly given to persons when sick with a physical illness. Such sick people may cause extra "trouble", but in spite of this one makes allowances and recognizes that the sick person can't help his sickness. Such sick people need sympathy and understanding.

The troubled person - the individual with an emotional or mental problem -

is also sick. Even though what he may do is disturbing to others, he too is just as much in need of sympathetic understanding as the physically ill person.

The second kind of understanding is rational understanding. This relates to an understanding of what's behind mental problems, why troubled people behave the way they do. This kind of understanding helps one to keep things in perspective. It helps to put one in a reasonable frame of mind to deal with the troubled person - in short, to help him rather than fight him.

Understanding Troubled People

Troublesome people are people in trouble ! The first step in understanding the troubled person is to realize that his disturbing behavior or problem behavior may be more painful to him than to anyone else. One should further recognize that troublesome behavior without apparent cause may be the effect of an emotional illness rather than a fault of character.

Some examples of disturbing behavior which indicate that a person is in emotional trouble include: belligerence; excessive moodiness; exaggerated worry; suspiciousness and mistrust; selfishness and greediness; helplessness and dependency; poor emotional control; day-dreaming and fantasy; and hypochondria.

Individuals experiencing mental problems have usually reached the level of illness as a result of earlier experiences. These distort their normal emotional responses and set up in them inappropriate and ineffectual ways of dealing with life situations. Each person is born with the capacity to be gentle, friendly, loving, considerate, and kind. Additionally, we have the capacity to be fearful, suspicious, hateful, angry, destructive, and cruel. These latter, negative emotions, may serve the purpose of self-preservation; i.e. they may act as devices to protect the individual from physical danger, (like an attack by a dog) as well as psychological danger, (like an insult or scolding, or insecurity on the job). Confronted by either kind of threat, we get scared and run, or else we turn on the source of danger and try to destroy or overcome it.

Should something happen in our lives to make us continually defensive or hostile, then this kind of response becomes more or less fixed as part of our regular way of behavior, even when no real threat is present. Such defensive or hostile behavior may develop as a result of several different kinds of experience, especially in childhood. Among these are:

(1) A long and wearing siege of trouble, sickness, tragedy or hard luck. This can condition a person to be on a constant alert for trouble.

(2) A constant air of doom and gloom in the home. If from infancy on, a child is surrounded by an air of fretting and complaint, he may grow up with the impression that the world is full of nothing but trouble, and that everyone is trying to take advantage of him. He is conditioned to anticipate trouble even when none exists. This attitude, formed in childhood, will tend to persist in adult life.

(3) Neglect or rejection in childhood. A child who is ignored or disliked may tend to feel this is his own fault, that he lacks the qualities to make him lovable and acceptable. The self-deprecating child becomes an adult full of insecurity, self-doubt and fear, lacking confidence and self-assurance and expecting to be hurt, ignored and rebuffed.

(4) Constant scolding and criticism. This may give the child an exaggerated feeling of guilt and a feeling he's inferior, worthless and essentially bad. He is conditioned to expect that everyone will find fault with him and punish him.

Obviously such experiences differentially affect children, for some can stand emotional stress better than others and suffer fewer lasting effects.

Do Give Helpful Understanding

For people troubled by emotional or mental problems, there are a number of things one can do, as well as some things that should be avoided.

(1) DO let the person know you're interested and care. Your friendly attitude

can help him let down his defenses and take a more relaxed attitude toward life.

(2) DO be a good listener. People with mental problems need someone to talk to, someone with whom they can share their troubles. One should make one-self available and, when the person starts talking, listen quietly and with little interruption.

(3) DO try to help out with some practical problem. Sometimes emotional difficulties may be provoked by some very simple, easy-to-adjust practical problems; like a study problem, a housing problem, difficulty on the job. Helping the person work out the problem may help relieve the emotional pressure, and put him in a better frame of mind to deal with his difficulties.

(4) DO read available literature. There is a considerable amount of inexpensive literature dealing with different, specific mental and emotional problems. This may lead to additional understanding and put one in a position to be helpful.

(5) DO get help from an expert. If the disturbance is prolonged and intense, indicating a serious problem, it may need the hand of an expert. In that case, one can be of assistance in making the person aware of these expert services.

If, however, emotional disturbances become too distressing to the troubled person or those around him, the situation should be dealt with as mental illness requiring professional treatment. In that case, help should be sought. Talk to a mental health professional - someone who specializes in the treatment of mental and emotional distress. Such treatment is available through community mental health clinics, mental hospitals, or the mental health units of general hospitals.

Dont's !

(1) DON'T set yourself up as a judge. Since problem behavior is a trouble rather than a fault, it is unfair (and it may even be harmful) to condemn the person as "weak" or "nasty" or "selfish". Fault-finding may only help to confirm his belief that everyone is against him.

(2) DON'T tell him to "snap out of it". In most cases the troubled person cannot help doing what he is doing, or stop doing it when told to, any more than a person with tuberculosis can stop coughing on demand. The problem is often so deep-seated that it will take much more than even a very strong, sincere desire to correct the problem behavior. Telling such a person to "snap out of it" can do little more than infuriate him, or make him feel even more helpless than he already does.

(3) DON'T argue him down. There is little point in trying to convince a troubled person that what he is doing is wrong. He has latched on to this kind of behavior as a means of protecting himself, and when you try to argue him out of it, it is like trying to take away the only defense he has. He will only resent this and fight you even harder.

(4) DON'T try to be an amateur therapist. Even the best intentioned people sometimes yield to the temptation to "act like an expert". This may be all right in trying to create an impression about literature or music, but when it comes to health and sickness there is only one expert - and that's the professional. For example, there may be some danger signals which you, not having the training, will fail to notice. You may also fall into the error of exaggerating the importance of some minor instance of disturbing behavior, and thus throw yourself and everyone else into a panic. If the problem looks more serious than can be helped by the "DOs" and DON'Ts" suggestions just described, then professional advice should be obtained.

Underlying all that has been said above is a basic philosophy - the philosophy of having faith; having faith in ourselves, faith in others, faith in the ability of each person to improve and grow, faith in the desire and capacity of human being to work out their problems cooperatively, faith in the essential decency of mankind. This basic philosophy is the underpinning of good mental health.

Help Prevent Mental Illness

Although knowledge about the causes of mental illness is limited, there is a body of knowledge which, if used, can help prevent emotional and mental illness. WE DO know there is;

(1) A clear relationship between mental disorders and the lack of medical attention.

Therefore - we can presently prevent some forms of mental disorder by protecting the brain and nervous system through adequate prenatal, obstetrical, and early infant care. We can make sure that comprehensive health care for senior citizens includes nutritional and other services concerned with factors related to senility. We can support immunization programs for children, as well as early and periodical screening for physical and developmental mental disorders.

WE DO know there is;

(2) An obvious relationship between mental health and the way in which people learn to cope with some "life crisis" situations.

Certain life experiences are almost universal and they are of such a critical nature that programs can be designed to increase the coping skills needed to deal with them. It may not be possible to demonstrate that the persons undergoing life crises would have developed mental illness had some intervention not been made. However, it is reasonable to assume that reduction of stress associated with the experience lowers the likelihood of emotional problems and future unhealthy coping practices.

Included among life crisis situations are admission to a hospital of a small child, separation of parent and child when the child just enters school, death in the family, the struggle for emancipation in adolescence, marriage, pregnancy, divorce, child rearing, loss of job, prolonged unemployment, and

retirement. Concentrated attention on preparation for effective handling of any specific critical situation can have demonstrable effects.

In addition, the training of teachers, employers, doctors, nurses, and even receptionists in health and service agencies to be aware of and sensitive to emotional stress can enable these people to avoid compounding stress. Such training can serve them also when it teaches them to make helpful interventions which provide emotional support to people under stress and needing reinforcement of their coping capabilities.

WE DO know there is:

(3) A distinct relationship between mental illness and excessive stress produced by the social systems of which people are a part.

While each of us has a degree of tolerance to stress, the pressure of multiple sources of significant emotional strain creates an increased likelihood of emotional breakdown. To prevent such breakdown, it is important to examine the social systems in which people live and from which stress may be produced beyond the limits of coping capacity.

Education, welfare, social services, and medical systems, to name but a few, often diminish the benefits which they have to offer by bureaucratic rigidities and other forms of insensitivity which compound the stress of people already in need of help.

Available evidence also demonstrates that the combination of hunger, crowding, discrimination and hopelessness in our city ghettos produces adaptive behavior which is mentally and emotionally unhealthy. Therefore - we can prevent mental illness by working to change these elements in our social systems which create multiple stress.

WE DO know there is:

(4) An obvious relationship between "labeling" and the prevalence of mental illness.

It is clear today that much of what is thought of as mental illness simply does not belong within that classification. Thus we can, in a sense, "prevent mental illness" simply by a more enlightened understanding of individual behavior and by avoiding the use of illness labels for behavior which is merely "different".

For example, if we could develop a greater acceptance of extremes in behavior we would broaden the limits of "normality" and thereby reduce the size of the population thought of as mentally ill. We should recognize that forgetfulness or vagueness of many elderly people stems from physical change due to the condition of aging, and is not really mental illness. This could reduce the stigmatized population even further. Such action would not be just a "nice thing to do". It would help to remove artificially created obstacles to a happy life and would help to prevent the terrible tragedy of unnecessary long-term hospitalization.

WE DO know there is:

(5) Other things we can do. The approaches described above can help to prevent mental illness before it really gets started. In addition, there are other things we can do to prevent mild problems from becoming serious illnesses. And also, to prevent mental illness from returning to those who have already experienced it. For example, early identification of inappropriate emotional and behavioral responses to stress, accompanied by proper diagnosis, and followed by quick and adequate treatment, can result in the return to normal functioning without serious consequences.

In addition, specialized rehabilitation facilities operated by well-trained personnel can enable the individuals who has been ill to become re-established in his or her social and employment connections. These reduce the consequences of his or her illness as well as diminish the likelihood of recurrence.

* * * * *

The above information was gleaned from the six Mental Health Association

publications^{cited} in the bibliography. The Mental Health Association is a nationwide, voluntary, non-governmental organization dedicated to the promotion of mental health, the prevention of mental illness, and the improved care and treatment of the mentally ill. Its 850 chapters and divisions, and more than one million citizen volunteers, work toward these goals through a wide variety of activities in social action, education, advocacy, and information.

Higher Education Student Mental Health Services

The need for student mental health services is the self-same need previously discussed. Approximately 1 out of 7 Americans have some form of mental or emotional illness and of these 7 million individuals it is estimated that less than one third of these troubled people in need of mental health assistance are now receiving it !

The Educational Resources Information Center (ERIC), sponsored by the National Institute of Education, publishes a monthly journal, Resources in Education (RIE). A computerized literature search in July 1979 of the entire ERIC data base on the topic, "Student Mental Health Services in Higher Education" yielded some 92 citation. Of these, 41 were directly pertinent to this topic; these are discussed in the following paragraphs.

To facilitate ready reference to this substantive number of documents, the major topics discussed in each article are summarized, by authors, in the listing immediately below. Additionally, the abstracts of these documents are presented after the listing, also following the same order as the listing of authors.

College Mental Health Centers::

(Authors listing, by topics, of documents abstracts which follow)

Functions, facilities & services of:

- 1- Hazard; 2- Amada; 3- Amaranto & Wegman;
- 4- Shaevitz; 5- Babineau & Schwartz; 6- Keepes; 7- Lewis & Neidig; 8 - Nigl & Weiss; 9 - Schwartz; 10- Rockwell; 11- Miller; 12- Demos; 13- Leavitt; 14- Nidorf;
- 15- Hunter; 16- Sinnatt; 17- WICHE; 18- WICHE; 19- WICHE; 20- National; 21 Niccolletti;

22- American; 23- Texas; 24- Kysar; 25- Kysar

Staffing of

26- Sue; 27- Winer; 28- Chirchirillo; 29- Jones & Najera; 30- Szasz

Clients (students) of

31- Nigl & Weiss; 32- Sue & Sue; 33- Reinhold; 34- Ledvinka & Denner; 35- Reifler;
36- Heilbrun; 37- Thelen & Vanble; 38- Wogan; 39- WICHE

Evaluations of

40- Michaels & Reifler; 41- Whitaker.

1- Hazard (1976) reports on a workshop discussing new trends in campus health care delivery. Stress was given to the repercussions of strong consumer demands for broader and more accessible health services and concerns for improved campus/community relations. The need for mental health care was recognized as an on-going concern within a comprehensive health care service.

2- Amada (1976) examines, through a survey, the presence of mental health services and programs among community colleges. He concludes that a paucity exists which needs to be changed.

3- Amaranto & Wegman (1977) report on the active growth of a mental health service in an academic health center - urban area; (New Jersey Medical School). The significant characteristic of the function is its limitation; i.e. limited strictly to therapeutic and consultative services for the students, operating as an outpatient treatment facility using a standard 12-session, goal-oriented treatment plan.

4- Shaevitz (1977) describes the dilemma faced by campus mental health/counseling professionals in seeking to maintain 'quality' services while operating under tighter budgets.

5- Babineau & Schwartz (1977) report encouraging results for solo therapists with adequate background in individual and couple therapy (who also have additional training/experience in sex therapy) in providing treatment for sexual dysfunction

to student couples in a health service setting.

6- Keeper (1977) in this paper is concerned with the various preventive measures which can be taken to minimize student emotional difficulties arising from life on the campus. Facilities on other campuses are reviewed with concentration on those aspects applicable to the University of Evansville, and specific recommendations are offered for a facility designed to fit its campus.

7- Lewis & Neidig (1977) discuss a successful, cooperative, short-term, crisis intervention, mental health program developed between Fulton-McDonough county community health center and the health service of Western Illinois University, with a fulltime consultant provided by the county health center and paid by the university.

8- Nigl & Weiss (1977 "Effects of.,etc") conclude from the results of a statistical study of student responses to a questionnaire designed to assess subjects' feelings toward treatment in a university mental health program, that college students can be treated effectively with brief psychotherapy.

9- Schwartz (1977) describes a novel group experience in career choice decision-making which permits students to receive help without identifying themselves as patients or clients. The therapeutic benefits are related to the satisfaction of psychological needs.

10- Rockwell (1977) suggests that brief group treatment is not a generally applicable device for managing students or for conserving staff time. His recommendation is for full use of individual counseling.

11- Miller (1976) offers two case descriptions which illustrate the work performed by a community college counseling service. The applicability of the term "psychotherapy" to the therapeutic services rendered is discussed. The implications for community mental health of such medical and educational service are examined.

12- Demos (1976) describes the highlights of a symposium which examined

the general roles and functions of a college counseling center and of the professional personnel in it focusing upon the fostering of positive mental health among college-age youth.

13- Leavitt (1971) discusses a mental health program at an urban community college, with emphasis placed on providing crisis services.

14- Nidorf (1970) describes the establishment and operation of a student service center at San Fernando Valley State College designed to assist students through active intervention to make a better adjustment to college environment.

15- Hunter (1969) discusses the role which can be played by a college mental health center clinic in identifying potential problem drinkers among college students.

16- Sinett (1969) describes the utilization of the rehabilitation unit, a new response for the emotionally disturbed student.

17- Western Interstate Commission for Higher Education (WICHE) (1974) released a report discussing consultation as a processes of assessment, defining, implementing, and evaluating. These steps are interrelated in a presentation of a consultation design for mental health services.

18- WICHE (1974) This report discusses how life on campus has been affected by changes in society and changes in the university's role. It illustrates how the change in priorities can be instrumental in resolving campus problems, and details the implications this holds for changing mental health delivery systems on campus.

19- WICHE (1972¹⁴) This report suggests that through the promotion of student unity, students can gain the necessary power to engage in representation conflict which will change the monolithic nature of education and present open, destructive conflict with the system. New designs promoting student responsibility, authority, and participation in the higher education system. These imply that mental health delivery systems on campus will have to become more open and involved, with

community programming and participation.

20- National Institute of Mental Health (1973) Facts about college mental health are presented. Areas of concern include common conditions interfering with student effectiveness; why students seek help and where they can get it; the frequency of severe mental illness in college students; the suicide problem; the limitations of non-professional help; the concept of dependency and counseling; methods of counseling used in a college setting; the relationship of violence to mental illness; availability of mental health services; the role of the college psychiatrist; and the ratio of mental health services on college campuses.

21- Nicoletti (1973) reports the results for forty undergraduates referred by counseling centers for anxiety management training (AMT). The AMT was found to be effective in reducing both generalized and public speaking anxiety.

22- American College Health Association (1972). The basic premise of this document is that every two-year college should have a plan through which the health needs of students, faculty, and staff can be met by available health services that are accessible and of high quality. Procedures for setting up a comprehensive health program are reviewed; various services and activities to be included are discussed in depth, as well as the health personnel and physical plant necessary for a complete program. Also reviewed are the business management procedures of a good health program.

23- Texas Tech University (1970) This paper contends that university campuses must find a reasonable, responsible, and financially defensible provision for mental health services. Results of responses by 73 universities to a psychiatric questionnaire survey are summarized, conclusions are drawn and recommendations offered.

24- Kysar (1966) College level preventive psychiatry should be directed toward biological, intrapsychic, familial, and social strains which disturb and distort students' learning experiences, causing short-term emotional difficulties.

Colleges have a unique opportunity to provide mental health prevention programs.

25- Kysar (196⁷) The combination of students from broken homes, from homes of lower socioeconomic status, and those students who have individual pathologies, result in a high rate of and a more severe psychopathology in commuter school students than in residential school students. The author concludes that the strong relationship existing between psychosocial difficulties and college drop-outs indicates the need for better college mental health programs.

26- Sue (197³) discusses a program to provide more responsive counseling services, in which minority students are trained to function as counselors for other minority individuals. He concludes that the training and utilization of minority-group paraprofessionals, as appropriate, are favorable alternatives to existing mental health services on campus.

27- Winer (1975) suggests, after a survey among clinic and mental health center directors, that many mental health professionals are not fully meeting their responsibilities to nonwhite students in the area of mental health services.

28- Chirchirillo (1977) addressing the general problem of mental health resources on most college campuses being taxed to their limits, discusses the feasibility of offering a program to develop the faculty's "counseling skills". He concludes that training faculty in such helping skills is a feasible community mental health approach to the college campus.

29- Jones & Najera (1977) conclude that in mental health illness crisis-therapy intervention for undergraduate students, effective interaction among mental health staff members and naturally concerned individuals (e.g. parents, friends, teachers) can be viewed as a network of help in such acute crisis intervention circumstances.

30- Szasz (1976) The principles of conduct governing college psychiatrists and the relationship between these authorities and their subjects are examined. The author concludes that much of the college psychiatrist's work consists of

crisis intervention and he is a powerful status figure with vast powers over the student.

31- Nigel & Weiss (1977) Forty-five students at the University of Cincinnati responded to an opinion survey concerning student attitudes toward the treatment they received, and about relevant consumer, demographic, and environmental variables,

32- Sue & Sue (1974^{4k}) found cultural differences between Asian students, when compared with control results, in the use of clinic services. The Asian students under-utilized the clinic and also possessed more pronounced Minnesota Multi-Phasic Personality Inventory scale elevations. Additionally, they exhibited problems involving somatic complaints, family discord, and social introversion.

33- Reinhold (1973) analyzes the clientele utilizing mental health services and the extent of such services at the University of Pennsylvania.

34- Ledvinka & Denner (1972) discuss a project of college student involvement in community-oriented health services relating to mental illness.

35- Reifler (1971) This paper summarizes information available on the prevalence of emotional disorder in the college experience. Data on the characteristics of users point toward the increasingly recognized importance of social affiliation; not only on mental health states but upon disposition to seek professional service.

36- Heilbrum (1970) This article assesses ability of the Adjective Check List to distinguish between clients of a college mental health facility who admitted to social alienation as a primary or secondary problem, and clients who denied the importance of this problem. Scores on various scales differed significantly for the problem and no problem client groups, male and female.

37- Thelan & Varble^(R16) report comparison of college students seeking psychotherapy with a similar group not seeking therapy. The former group generally had higher defense and lower coping scores than the latter.

38- Wogan (1975) This paper discusses the effects of pretraining counseling clients for group therapy sessions. The findings suggest that types of pre-treatment employed were relatively ineffective in influencing the subsequent process in the groups. The interaction seemed to be much more highly influenced by level of activity of the leader. Groups which rated themselves as most improved tended to be those in which there was more discussion of personal feelings and where the leader was more active.

39- WICHE (197⁴) provides in this document a research design by which to gather accurate, descriptive base-line data on campus and student characteristics so that mental health personnel can assume a proactive role in the planning and conducting of educational programs that ameliorate student problems and/or enhance school and student educational goals.

40- Michaels & Reifler (1977) suggest that mental health programs, in addition to providing health services that are justifiable in a cost/benefit analysis, provide services promoting the quality of life. The latter, they note, are not justifiable from this cost/benefit viewpoint and must compete with other humanistic university programs.

41- Whitaker (1977) presents data relating to research and statistical surveys on student health services and problems at community colleges which reveal administrative attitudes, student health care needs, and areas for improvement. Providing health care for students is said to be generally overlooked by community college professionals who feel it should not be the college's responsibility. A lack of both medical treatment facilities and mental health programs on community college campuses is identified. Suggestions for implementing comprehensive health care programs are offered by Whitaker.

A Final Comment**

The articles which are abstracted immediately above suggest

**Information taken from: "How To Deal With Your Tensions" Mental Health Assoc.
370-037-78

that the "state of the art" for mental services offered to student attending colleges and universities is rather uneven across the country. Although there is evidence that some institutions offer comprehensive mental health services, it is also apparent that for numerous others mental health services are conspicuous by their absence.

Among college students, as well as other individuals, the quest for peace of mind (or good mental health) is a universal one. The average human being has the capacity to live through emotionally upsetting situations - even crises - and bounce back when they are over. It is therefore important for a student to recognize that an occasional bout of anxiety and tension is quite normal, and while it may be unpleasant or even painful, it need not be a cause for additional concern.

However, there are some students for whom life is a series of little and big crises. In such instances one might expect more than an occasional passing emotional upset. Signs of prolonged and intense anxiety and tension may be expected. Thus the time to become watchful is when emotional upsets come frequently, shake the student severely, and persist.

How does one recognize that this build-up is happening? Stated as questions, here are some of the effects that show. If any considerable number of these reactions are getting to be the rule for a student, that does not mean disaster. But it does indicate the need to deal with the situation constructively:

- 1- Do minor problems and disappointments throw the student into a dither?
- 2- Does the student find it difficult to get along with people, and are people having difficulty getting along with the student?
- 3- Do the small pleasures of life fail to satisfy the student?
- 4- Is the student unable to stop thinking of his anxieties?
- 5- Does the student fear people or situations that never troubled him previously?
- 6- Is the student suspicious of people, mistrusting his friends?

7- Does the student have the feeling of being trapped?

8- Does the student feel inadequate; suffer the tortures of self-doubt?

If the answer is "Yes" to most of these questions, there are several things the student might do. To begin with, there are certain simple, practical constructive things the student can do for himself. For the most part, these measures are positive forms of action. They are simple, ready-at-hand measures.

However, success will not come, even in these, if the student's effort is halfhearted. Nor will it come overnight. It will take determination on the part of the student, as well as persistence and time. (The following eleven numbered paragraphs are written as if addressed directly to the troubled student).

1. Talk it out;

When something worries you, talk it out. Don't bottle it up. Confide your worry to some levelheaded person you can trust; your roommate, a friend, father or mother, sister or brother, your clergyman, your family doctor, a teacher, counselor or dean. Talking things out helps to relieve your strain. It helps you to see your worry in a clearer light, and often helps you to see what you can do about it.

2. Escape for a while;

Sometimes, when things go wrong, it helps to escape from the painful problem for awhile; to lose yourself in a movie or a book or a game, or a brief trip for a change of scene. Making yourself "stand there and suffer" is a form of self-punishment, not a way to solve a problem. It is perfectly realistic and healthy to escape punishment long enough to recover breath and balance. But be prepared to come back and deal with your difficulty when you are more composed, and when you and others involved are in better condition to deal with it.

3. Work off your anger;

If you feel yourself using anger as a general way of behavior, remember that while anger may give you a temporary sense of

righteousness, or even of power, it will generally leave you feeling foolish and sorry in the end. If you feel like lashing out at someone who has provoked you, try holding off that impulse for awhile. Let it wait until tomorrow. Meanwhile, do something constructive with the pent-up energy. Pitch into some physical activity; jogging, tennis, a long walk. Working the anger out of your system and cooling it off for a day or two will leave you much better prepared to handle your problem.

4. Give in occasionally:

If you find yourself getting into frequent quarrels with people, and feeling obstinate and defiant, remember that that's the way frustrated children behave. Stand your ground on what you know is right, but do so calmly and make allowance for the fact that you could turn out to be wrong. And even if you're dead right, it's easier on your system to give in once in a while. If you yield, you'll usually find that others will, too. And if you can work this out, the result will be relief from tension, the achievement of a practical solution, together with a great feeling of satisfaction and maturity.

5. Do something for others:

If you feel yourself worrying about yourself all the time, try doing something for somebody else. You'll find this will take the steam out of your own worries and - even better - give you a fine feeling of having done well.

6. Take one thing at a time:

For people under tension, an ordinary work load can sometimes seem unbearable. The load looks so great that it becomes painful to tackle any part of it - even the things that most need to be done. When that happens, remember that it's a temporary condition and that you can work your way out of it. The surest way to do this is to take a few of the most urgent tasks and pitch into them, one at a time, setting aside all the rest for the time being. Once you dispose of these you'll see that the remainder is not such a "horrible mess" after all. You'll be in the swing of things, and the rest of the tasks

will go much more easily. If you feel you can't set anything aside to tackle things this sensible way, reflect; are you sure you aren't overestimating the importance of the things you do - that is, your own importance?

7. Shun the "Superman" urge;

Some people expect too much of themselves, and get into a constant state of worry and anxiety because they think they are not achieving as much as they should. They try to be perfect in everything. Decide which things you do well, and then put your major effort into these. They are apt to be the things you like to do, hence, those that give you most satisfaction. Then, perhaps, come the things you can't do so well. Give them the best of your effort and ability, but don't take yourself to task if you can't achieve the impossible.

8. Go easy with your criticism;

Some people expect too much of others, and then feel frustrated, let down, disappointed, even "trapped" when another person does not measure up. The "other person" may be a friend, brother, or sister whom we are trying to fit into a preconceived pattern - perhaps even trying to make over to suit ourselves. Remember, each person has his own virtues, his own shortcomings, his own values, his own right to develop as an individual. People who feel let down by the shortcomings (real or imagined) of their relatives, are really let down about themselves. Instead of being critical about the other person's behavior, search out the good points and help him to develop them. This will give both of you satisfaction and help you to gain a better perspective on yourself as well.

9. Give the other fellow a break;

When people are under emotional tension, they often feel that they have to "get there first" - to edge out the other person, no matter if the goal is as trivial as getting ahead on the highway. If enough of us feel that way - and many of us do - then everything becomes a race

in which somebody is bound to get injured - physically, as on the highway, or emotionally and mentally, in the endeavor to live a full life. It need not be this way. Competition is contagious, but so is cooperation. When you give the other fellow a break, you very often make things easier for yourself; if he no longer feels you are a threat to him, he stops being a threat to you.

10. Make yourself "available";

Many of us have the feeling that we are being "left out", slighted, neglected, rejected. Often, we just imagine that other people feel this way about us, when in reality they are eager for us to make the first move. It may be we, not the others, who are depreciating ourselves. Instead of shrinking away and withdrawing, it is much healthier, as well as more practical, to continue to "make yourself available" - to make some of the overtures instead of always waiting to be asked. Of course, the opposite of withdrawal is equally futile; to push yourself forward on every occasion. This is often misinterpreted and may lead to real rejection. There is a middle ground. Try it.

11. Schedule your recreation;

Many people drive themselves so hard that they allow themselves too little time for recreation - an essential for good physical and mental health. They find it hard to make themselves take time out. For such people a set routine and schedule will help - a program of definite hours when they will engage in some recreation. And in general it is desirable for almost everyone to have a hobby that absorbs him in off hours - one into which he can throw himself completely and with pleasure, forgetting all about work.

At times, any one of us might need help greater than that offered by the eleven simple suggestions noted immediately above. Under such circumstances it may be helpful to seek the assistance of a counseling and guidance service which specializes in helping people work out their practical problems. They

help people clear up practical problems; thus helping to relieve emotional strain. It is always well to seek such practical help first.

However, if emotional disturbances become too distressing to the person or to others, it should be recognized and dealt with as mental illness requiring professional treatment. If the troubled person requires such help, get an expert !

1979

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